VSH Futures Advisory Committee
December 18, 2006 2:00 – 4:30 PM

Minutes

Next meeting: January 22, 2007 2:00 p.m. to 4:30 p.m.
Skylight Conference Room - State Office Complex, Waterbury

Present

Advisory Committee Members: Ron Smith, DOC; Greg Miller, Retreat Healthcare; Jeff Rothenberg, CMC; Jack McCullough, MHLP; Sandra Steingard, HCHS; Stan Baker, HCHS/DD/Autism Division; Sally Parrish, advocate; Michael Hartman, WCMH; David Fassler, VPA; Conor Casey, VSEA; Paul Dupre, Vermont Council; Meg O'Donnell, FAHC; Jill Olson, VAHHS; Ken Libertoff, VAMH; Ed Paquin, VP&A; Larry Lewack, NAMI-VT; Xenia Williams, advocate; Michael Sabourin, advocate; Anne Jerman, VSH; JoEllen Swaine, VSH; Larry Thomson, VSH

Guests:
Doreen Chambers, BISHCA; Monica Mead, Waterbury Record; Julie Tessler, Vermont Council; Roy Riddle, Second Spring; Susan Gretkowski, MacLean, Meehan & Rice; Rep. Anne Donahue; Peter Albert, Retreat Healthcare.

Staff:
VDH Acting Commissioner Sharon Moffatt; Beth Tanzman, Judy Rosenstreich, Norma Wasko, Dawn Philibert and Bill McMains, VDH/DMH; Wendy Beinner and Jessica Oski, AAG/DMH.

Introductions and Updates
Acting Commissioner Sharon Moffatt convened the group, offering a warm welcome to Michael Hartman in his new leadership role as Deputy Commissioner of the Vermont Department of Health's Division of Mental Health. Members of the Advisory Committee joined in congratulating Michael and offered their support. Commissioner Moffatt stated that Michael will officially assume the post about the third week in January; however, he will begin preparing for his new duties as he completes responsibilities for Washington County Mental Health Services.

VERMONT STATE HOSPITAL GOVERNING BODY
Commissioner Moffatt asked committee members to come prepared to discuss governance options for Vermont State Hospital at the next meeting of the Futures Advisory Committee. A memo, by Wendy Beinner, AAG, Chief Counsel offers a summary of options.

RESPONSE TO POC HEARING

Commissioner Moffatt invited thoughts on the Public Oversight Commission's (POC) hearing of the State's application for a conceptual Certificate of Need (CCON) for planning. Beth explained that based on the deliberations, the POC seems likely to grant a planning CON with conditions. The POC expects to complete its deliberations in January and make a recommendation to the Commissioner of BISHCA.

In roundtable discussion, Advisory members aired their thoughts.

- Ed Paquin suggested re-thinking our approach.
- Ken Libertoff reminded colleagues that we are planning on a 50-year horizon, meaning the program(s) and structure must be designed to serve Vermonters' needs well into the future.
- David Fassler saw the POC reaction as a setback to closing VSH. POC members need us to explain step-by-step how we arrived at our proposal for an inpatient program integrated with an academic medical center.
- Paul Dupre suggested that the number of inpatient beds needed depends on the extent of community resources.
- Larry Lewack heard the POC signal their interest in the whole system of care, not only bricks and mortar. Questions of BISHCA jurisdiction not withstanding, the mental health community should focus on common ground and shared values.
- Bill McMains observed that the testimony provided to the POC from interested parties did not show commonality and, as long as this prevails, external agencies such as BISHCA are unlikely to line up in support of the Futures plan.
- Sandy Steingard acknowledged the complexity of the planning process involving different branches of state government. Given this challenge, it was all the more important that the mental health community reach consensus. It was very strange to see the same organizations who five years ago advocated integration provide testimony to the POC that barely mentioned the importance of integration.
- Commissioner Moffatt responded with two thoughts, first, to re-center ourselves around common values at the January meeting and, second, to consider bringing together the inpatient work group as a POC-response group. Beth reviewed the original charge of the Inpatient Work Group, including consideration of single or multiple sites and development of criteria to establish partners. A new work group would require us to clarify its charge.
- Michael Hartman advised colleagues not to be deterred by the tone of the POC hearing, suggesting we may want to create a POC-response group to process the comments.
- Greg Miller recommended staying with the primary strategy while, at the same time, giving consideration and analysis to other possibilities.
- Larry Thomson was interested in outcome measures across 2-3 different models.
- Jack McCullough was not at the POC. Given the strong message, he agreed with Michael that we plan for discussion at the next Advisory meeting.

A suggestion was made that Michael Hartman, as incoming Deputy Commissioner, try a new approach, possibly selecting a group of people to form a group to think about next steps. This would be different from how the Advisory Committee has operated but could

be more effective. David cautioned against any approach involving a selection of members from the Advisory Committee.

Commissioner Moffatt spoke about the POC planning process, indicating that it needs to be an open process, in response to Conor Casey questioning the State's plan at this point.

PUBLIC COMMENT

Legislature commissioned the Futures planning process for the whole system and subsequently decided that BISHCA review was appropriate. The POC role provides accountability to the planning process, offered Anne Donahue.

CRISIS BEDS FINANCIAL ANALYSIS REPORT

At its October 2006 meeting, the Advisory Committee accepted the Crisis Beds Work Group report and voted in support of the priority action steps. In addition, the committee asked the work group to further develop its recommendations to specify the number of crisis beds recommended and the funding required for new crisis beds as well as full funding of the emergency services system.

Working with the Division of Mental Health, the work group produced a financial analysis that presents the cost of the proposed increase in crisis bed capacity and what would be required to fully fund emergency services. Jeff Rothenberg handed out a summary of the financial analysis report, which provided the methodology used and recommended budget allocations required to phase in full funding of emergency services and new crisis bed programs for the system of care.

Beth gave an overview of the work done by the division in 2001 to quantify what a basic emergency services system would consist of and how much it would cost. The cost per bed of crisis stabilization beds also was established. From this analysis, the work group developed financial projections concerning its two primary recommendations:

1) Emergency Services >>> full funding for a basic capacity of Mental Health Emergency Services for the entire system.
2) Crisis Bed Programs >>> expansion of the number of recommended new crisis beds and cost.

<u>Discussion</u>
In a lengthy discussion, the committee grappled with several issues:

- Concern that separate recommendations for housing and crisis beds does not include other proposed capacities in the Futures Plan such as wraparound services. (David)
- Need a full chart with all the pieces to build a recovery-oriented system
- Will quality outcomes be measured? (Peter)

- A key issue in crisis services is that you have to pay for capacity even if it is not used. Did the work group consider the appropriate vacancy rate for crisis bed programs? (Bill)
- Crisis beds are not necessarily cheaper than hospitalization. Staff must be available and paid. Recommend $200,000 annually per bed as a more realistic cost. (Paul)
- Value of hospital diversion, having people in least restrictive setting and at less cost than inpatient. (Sandy)
- The capacity---the number of crisis beds proposed in today's work group report---seem very large compared to the need identified by CRT and Emergency Services directors from the October report. (Michael Hartman)
- Appreciate the recommendation that the practices for crisis beds and emergency services generally should become more standardized across the system of care.
- What is the fiscal framework for the Futures project? What should it all cost? (Ken)
- Any proposal that adds residential beds will assist in step-down and transition from VSH. (Larry Thomson)
- Shift in thinking from assumption in Secretary Charlie Smith's report that the new services created would be cost neutral due to reduction in inpatient care and expansion of Medicaid-supported funding. There is growing recognition that community services meet our values although they may not necessarily be cheaper. (Anne and Ken)
- Second Spring costs are even swap with VSH.[1] As we reduce inpatient census, the cost in the community may not be reduced. (Paul)
- With recommendations on housing and crisis beds in hand, we must build budget and quality into Futures' programs and services. (Ken)
- As community beds are generally considered less coercive, the need for inpatient bed capacity should follow efforts to develop the community system as much as we can. (Michael Sabourin)
- Forwarding the recommendations on emergency services and crisis bed programs to Secretary LaWare is appropriate; however, the Futures Plan should be updated with respect to the bigger picture, including housing, crisis beds, transportation, peer run services and secure residential. (David)

Commissioner Moffatt focused on the summary of the recommendations of the Crisis Beds Development Work Group. This will be forwarded to Secretary LaWare.

The suggestion was made to add a fourth recommendation to the summary. This recommendation was supported generally by the committee and reads as follows:

4) Establish clear outcome assessments for crisis bed programs that evaluate:

- *Impact of diversion on inpatient days*
- *Quality of care indicators*
- *Quality of post-acute care indicators; and*
- *Impact on realizing system values.*

[1] DMH Note: The daily cost for Second Spring is less than the daily cost for VSH.

Continued Discussion

The erosion in funding for emergency services was emphasized, noting that the HRAP Recommendation #2 calls for strengthening support for this part of the system.

Greg stated that inpatient diversion beds should be co-located with general hospitals or within close proximity to a medical facility to provide seamless access to medical services as crisis situations are often related to medical issues. Drawing a distinction between hospital diversion beds and crisis beds, Greg suggested that the former would provide medically-based care in lieu of hospitalization while the latter, crisis beds, would provide a supportive environment to de-escalate a mental health crisis.

Jack shared his impression that Home Intervention, for example, works in part because it is *not* a hospital but rather a voluntary program. Providing this service in a hospital setting may change this.

Calling the crisis beds/emergency services report a quality piece of work, Ken suggested that the Advisory Committee endorse the recommendations as amended by the addition of recommendation #4 (re: outcome assessments) so that the Secretary may consider the same in the budget process.

- MOTION: Ken moved/Xenia seconded to accept the recommendations of the Crisis Beds Development Work Group of $2.8 million for 14 new beds in FY 08 ($200,000 / bed) and a $1 million enhancement for emergency services in FY 08, totaling $3.8 million.

  VOTE: 15 in favor, none opposed, no abstentions

The meeting adjourned at 4:30 p.m.

SUBMITTED BY: Judy Rosenstreich
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